This Contract has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Notice of Right to Examine Contract. Within 30 days after delivery of this Contract to You, You may return it to Us for a full refund of any Premium paid, less services provided. The Contract will be deemed void from the beginning.

[CARRIER]
HEALTH MAINTENANCE ORGANIZATION BENEFITS PLAN
(New Jersey HMO Health Benefits Plan)

Contract Term. The Contract takes effect on[_____,] the Contract Effective Date. The term of this Contract starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You first become eligible as set forth in Section II of this Contract. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Contract.

Renewal Provision. Subject to all Contract terms and provisions, including those describing Termination of the Contract, You may renew and keep this Contract in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Contract.

Premiums. We may only change the Premiums for this Contract if We change the Premiums for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this HMO Health Benefits Plan.

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DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help You to understand what services are provided. Information about the services provided under this Contract begins on page ____.

ALCOHOLISM. Abuse of or addiction to alcohol. Alcoholism does **not** include abuse of or addiction to a substance. Please see the definition of Substance Abuse.

AMBULANCE. A certified vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

[ASSOCIATED MEDICAL GROUPS. Any Medical Group with which we contract directly to provide Covered Services to Members including the [ ]].

BIOLOGICALLY-BASED MENTAL ILLNESS. A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give Medical Emergency care; and
c) have written back-up arrangements with a local Hospital for Medical Emergency care.

It must also:

a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CHILD. A person who is unmarried and under the age of 19. In some cases, a person who is age 19 or older may be considered a Child. Refer to items a)3 and b) of the DEPENDENT definition.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered Services.]

CONTRACT. This agreement, [the Contract Schedule,] [Your I.D. card,] any riders, amendments or endorsements, the application signed by You and the Premium schedule.

CONTRACTHOLDER. The person who purchased this Contract.

CONTRACT TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Contract is renewed each one-year period thereafter.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Services or Supplies. Note: The Emergency Room Copayment, if any, must be paid in addition to any other Copayments and Coinsurance.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Contract. The services and supplies must be:

a) furnished or ordered by a recognized health care Provider;
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury or provide Preventive Care;
c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. With respect to an individual, coverage of the individual under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter

89 of Title 5, United States Code; a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

CUSTODIAL CARE. Any service or supply, including room and board, which:
a) is furnished mainly to help You meet Your routine daily needs; or
b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.
a) Your:
1) Spouse;
2) Child who is Your own issue, Your legally adopted Child, or Your step-Child; or a Child related to You by blood, if the Child depends on You for most of the Child's support and maintenance and resides in Your household. We treat a Child as legally adopted from the time the Child is placed in the household for the purpose of adoption. We treat a Child this way whether or not a final adoption order is ever issued. Also, any other Child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship is considered a Dependent Child under this Contract provided the Child depends on You for most of the Child's support and maintenance and resides in Your household. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, residency in Your household, blood relationship or legal relationship, in Our Discretion.)
3) unmarried Child from age 19 until the Child's 23rd birthday, who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled) ; and
4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

b) Your unmarried Child who satisfies the requirements for a DEPENDENT, according to item a)2 of the DEPENDENT definition, and who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Contract's age limit, if:
1) the Child remains unmarried and unable to be self-supportive;
2) the Child's condition started before the Child reached this Contract's age limit;
3) the Child became insured before the Child reached this Contract's age limit, and stayed continuously insured until the Child reached such limit; and
4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this Contract's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION/DETERMINATION /DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily for a medical purpose;
c) mainly and customarily used to serve a medical purpose;
d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Contract for You or Your Dependents, as the context in which the term is used suggests.

ELIGIBLE PERSON. A person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. δ 1395 et. seq.) (Medicare). Refer to the **Who is Eligible** provision of the **ELIGIBILITY** section.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

-The American Medical Association Drug Evaluations;
-The American Hospital Formulary Service Drug Information; or
-The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-

designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place which:

a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Contract.

FEDERALLY DEFINED ELIGIBLE INDIVIDUAL. An Eligible Person, as defined:

a) for whom, as of the date on which he or she seeks coverage under this Contract, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item “e” above, and has exhausted that continuation coverage.

GOVERNMENTAL PLAN. Has the meaning given that term under Title I, section 3 of Pub.L.93-406, the “Employee Retirement Income Security Act of 1974” and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

GROUP HEALTH PLAN. An employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(1)) to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract, medical service corporation contract, or health maintenance organization subscriber contract or other plan for medical care delivered or issued for delivery in New Jersey. For the purpose of this Contract, Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

HEALTH STATUS-RELATED FACTOR Any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of domestic violence; and disability.

[HEALTH CENTER (or HEALTH CARE CENTER) - Any place operated by or on behalf of an HMO where a [Network] [Participating] [Provider] [Practitioner] Provides Covered Services and Supplies to Members]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate or reduce Hospital stays. The agency must be licensed by the state in which it operates, or be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It carries out its stated purpose under all relevant state and local laws, and it is:

a) approved for its stated purpose by Medicare ;
b) accredited for its stated purpose by the Joint Commission; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Injured people. It carries out its stated purpose under all relevant state and local laws, and it is :

a) accredited as a hospital by the Joint Commission;
b) approved as a hospital by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or for Substance Abusers or Alcoholics is not a Hospital. A specialty Facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You.

INJURY (OR INJURED). All damage to a Member's body and all complications arising from that damage.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Organizations.

[MAINTENANCE DRUG. A Prescription Drug used for the treatment of chronic medical conditions including but not limited to: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes(oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders.]

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function.

Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain, or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath, appendicitis, strokes, convulsions, serious burns, bone fractures, wounds requiring

sutures, poisoning, and loss of consciousness. We may, in Our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Injury;
b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Injury;
c) in accordance with accepted medical standards in the community at the time;
d) not for Your convenience; and
e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An Eligible Person who is covered under this Contract.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. The Facility must carry out its stated purpose under all relevant state and local laws, and be:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.]

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

In Determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Contract, or which are specifically identified as Non-Covered Services.

NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and are covered by this Contract.

OUTPATIENT. You, if You are registered at a recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Non-Biologically-based Mental Illnesses consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay). For the purpose of benefit limitations, Partial Hospitalization days are considered as Outpatient visits.

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Contract:

a) as a Member; and
b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

PLAN SPONSOR has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. δ 1002(16)(B)). That is:

a) the employer in the case of an employee benefit plan established or maintained by a single employer;
b) the employee organization in the case of a plan established or maintained by an employee organization; or
c) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board or trustees, or other similar group of representatives of the parties who establish or maintain the plan.

PRACTITIONER. A person who:

a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate and which are covered by this Contract.

PREMIUM. The periodic charges due under this Contract which the Contractholder must pay to maintain this Contract in effect.

PRE-ADMISSION TESTING. Consultations, X-rays and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before Your coverage under this Contract starts, and for which:

a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the exclusions section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Contract.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution - Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a Practitioner specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] [or Health Center] that directs You to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Injured people. It carries out its stated purpose under all relevant state and local laws, and it is:

a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

RESIDENT. A person:

a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It carries out its stated purpose under all relevant state and local laws, and it is:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

SPECIALIST PRACTITIONER. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.

SPOUSE. An individual legally married to the Contractholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does **not** include abuse of or addiction to alcohol. Please see the definition of Alcoholism.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. The Facility must carry out its stated purpose under all relevant state and local laws, and be:

a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) licensed, certified, or accredited for its stated purpose by the state in which it operates.

SURGERY.

a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) Reasonable and Customary pre-operative and post-operative care; or
d) any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b) have permanent operating and recovery rooms;
c) be staffed and equipped to give emergency care; and
d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is:

a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care;
b) approved for its stated purpose by Medicare; or

c) licensed, certified or accredited for its stated purpose by the state in which it operates.

A Facility is not a Surgical Center if the Facility is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from an Injury or Illness:
Chelation Therapy - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.
Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.
Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.
Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
Respiration Therapy - the introduction of dry or moist gases into the lungs.
Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Contract. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Contractholder and/or any Member, as the context in which the term is used suggests.

ELIGIBILITY

TYPES OF COVERAGE

A Contractholder who completes an application for coverage may elect one of the types of coverage listed below:

a) **SINGLE COVERAGE** - coverage under this Contract for only one person.
b) **FAMILY COVERAGE** - coverage under this Contract for You and Your Dependent(s).
c) **ADULT AND CHILD(REN) COVERAGE -** coverage under this Contract for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
d) **HUSBAND AND WIFE COVERAGE** - coverage under this Contract for You and Your Spouse.
e) **[CHILD(REN) COVERAGE** - Coverage under this Contract for a Child or multiple Children who are members of the same household and who depend on the Contractholder for most of their support and maintenance.]

WHO IS ELIGIBLE

a) **THE CONTRACTHOLDER** -You, if You are an Eligible Person, [who lives, resides or works in the designated Service Area in the State of New Jersey] **except** as provided below.
b) **SPOUSE** - Your Spouse [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person **except:** a Spouse need not be a Resident; and except as provided below.
c) **CHILD** - Your Child [who lives, resides or works in the designated Service Area in the State of New Jersey.], who is an Eligible Person and who qualifies as a Dependent, as defined in this Contract , **except**: a Child need not be a Resident; and except as provided below.

In order to obtain and continue health care coverage with Us, the Member, who is not covered as either a Dependent Spouse or as a Dependent Child, must be a Resident. We reserve the right to require proof that such Member is a Resident.

ELIGIBILITY IF YOU HAVE OR ARE ELIGIBLE FOR OTHER COVERAGE

a) **ELIGIBILITY IF YOU ARE COVERED UNDER ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN** - You and/or Your Dependents are eligible for coverage under this Contract if this Contract replaces another Individual Health Benefits Plan under which You and/or Your Dependents are covered. You may request termination of the replaced Individual Health Benefits Plan pursuant to the termination provisions of that Plan. We may require proof that the other coverage has been terminated.
b) **ELIGIBILITY IF YOU ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFITS PLAN** - You and/or Dependents may be eligible for coverage under this Contract only during the open enrollment period which occurs each year during the

month of October for an effective date of January 1 of the following year. Consult Us or Your agent for more information.

ADDING DEPENDENTS TO THIS CONTRACT

a) **SPOUSE** - You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

   If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

b) **NEWBORN DEPENDENT** - A Child born to You or Your Spouse while this Contract is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

   To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Adult and Child(ren) or Family Coverage. If You already have Family or Adult and Child(ren) coverage, the coverage for such Child will be automatically continued provided the premium required for Adult and Child(ren) or Family Coverage continues to be paid [.] [and You notify Us of the birth of the newborn Child within 31 days of the date of birth.]

c) **CHILD DEPENDENT** - If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Adult and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

   Even if You have Family Coverage or Adult and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

   If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

d) **YOUR CHILD DEPENDENT'S NEWBORN** - A Child born to Your Child Dependent is not covered under this Contract.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR, UNLESS OTHERWISE STATED. BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

FACILITY BENEFIT Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT	$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500 / Calendar Year.
OUTPATIENT	$15 Copayment/visit

PRACTITIONER SERVICES:

INPATIENT	None
OUTPATIENT	$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM $50 Copayment/visit/Member (credited toward Inpatient admission if admission occurs within 24 hours as the result of the emergency).

ALCOHOLISM:

OUTPATIENT	$15 Copayment/visit for a maximum of 20 visits / Benefit Period.
INPATIENT	$150 Copayment/day for a maximum of 5 days / admission. Maximum Copayment $1,500/Calendar Year. Maximum of 30 days Inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

AMBULATORY SURGERY $15 Copayment/visit.

BIRTHING CENTERS $15 Copayment/visit.

HOME HEALTH CARE Unlimited days, if preapproved.

HOSPICE CHARGES Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE) $25 Copayment/initial visit.

NON-BIOLOGICALLY-BASED MENTAL ILLNESSES AND SUBSTANCE ABUSE:	
OUTPATIENT/ PARTIAL HOSPITALIZATION	$15 Copayment/visit for a maximum of 20 visits / Benefit Period.
INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year. Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits or Partial Hospitalization Days.
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES	$15 Copayment/visit.
PREVENTIVE CARE	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if the Admission is immediately preceded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CARE	Unlimited days, if preapproved.
THERAPEUTIC MANIPULATION	$15 Copayment/visit for a maximum of 30 visits per Calendar Year.
THERAPY SERVICES	$15 Copayment/visit.
X-RAY & LAB (OUTPATIENT)	$15 Copayment/visit.

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY CARE PHYSICIAN, CARE MANAGER OR HEALTH CENTER AS APPLICABLE. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS Contract CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Contract are [shown in the Contract's Schedule of Premium Rates]:

For Single Coverage	[$]
For Adult and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Husband and Wife Coverage	[$]
[For Child(ren) Coverage	$]

We have the right to change any Premium rate set forth [above] at the times and in the manner established by the provision of this Contract entitled "Premium Rate Changes."]

PREMIUM AMOUNTS
The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

a) the amounts of the Premium charges for the Member that was included in the Premiums paid for the two-month period immediately after the date the Member's coverage has ended.
b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Contract]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Contract is in force in order for this Contract to be considered in force on a premium paying basis. If any premium is not paid by the end of the grace period, [this Contract will continue in force without premium payment during the grace period and this Contract will end when the grace period ends.][coverage will end as of the end of the period for which premium has been paid. You may be responsible for the payment of charges incurred for services or supplies received during the grace period.] [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

REINSTATEMENT

If We, or one of Our duly authorized agents accept the payment of premium after the end of the grace period without requiring an application for reinstatement, such acceptance of premium shall reinstate the Contract. However, if We or one of Our duly authorized agents require an application for reinstatement and issue a conditional receipt for the premium paid, the Contract will be reinstated upon Our approval of the application, or lacking Our approval, it will be reinstated on the forty-fifth day following the date for the conditional receipt unless We have previously notified You of Our disapproval of the reinstatement application. The reinstated Contract shall cover only loss resulting from Injury or Illness that begins more than 10 days after the date of reinstatement. In all other respects, We and the Member shall have the same rights under the Contract as before the end of the grace period.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the [Premium Rates and Provisions section of the Contract] [Contract's Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

a) any Premium Due Date;
b) any date that the extent or nature of the risk under the Contract is changed:
- by amendment of the Contract; or
- by reason of any provision of law or any government program or regulation;

c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Contract.

We will give You 30 days written notice when a change in the Premium rates is made.

COVERED SERVICES AND SUPPLIES

You are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by You of applicable Copayments as stated in the applicable Schedule of Services.

a) **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by You, or elsewhere upon prior written referral by Your [Primary Care Physician] [Health Center] or [Care Manager]:

1) **Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate.
2) **Home visits** by your Primary Care Physician.
3) **Periodic health examinations** to include:
    a) Well child care from birth including immunizations;
    b) Routine physical examinations, including eye examinations;
    c) Routine gynecologic exams and related services;
    d) Routine ear and hearing examination; and
    e) Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of Your employment).

4) **Diagnostic Services**.

5) **Casts and dressings**.
6) **Ambulance Service** when certified in writing as Medically Necessary and Appropriate by Your [Primary Care Physician] [or Care Manager] and approved in advance by Us [or the Care Manager] .
7) **Infertility Services** except where specifically excluded in this Contract.
8) **Prosthetic Devices and Durable Medical Equipment** when ordered by your Primary Care Physician [or Care Manager] and arranged through Us. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, or wigs. We do not cover dental prosthetics or devices other than as a replacement for natural teeth lost due to Injury as stated in the Dental Care and Treatment provision of this Contract.
9) **Prescription Drugs** and contraceptives which require a Practitioner's prescription and the following non-prescription drugs and supplies: insulin needles and syringes and glucose test strips and lancets; colostomy bags, belts and irrigators
10) **Nutritional Counseling**. for the management of disease entities which have a specific diagnostic criteria that can be verified. The Nutritional Counseling must be prescribed by a Primary Care Physician and approved in advance by Us.

b) **SPECIALIST PRACTITIONER BENEFITS.** Services of a Specialist Practitioner are covered when rendered by a [Network] [Participating] Specialist Practitioner at the Practitioner's office [, or Health Center] or at a [Network] [Participating] Hospital outpatient department during office or business hours upon prior written referral by Your Primary Care Physician [or Care Manager]

c) **INPATIENT HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a [Network] [Participating] Practitioner upon prior written referral from Your Primary Care Physician [Care Manager], only at [Network] [Participating] Hospitals and [Network] [Participating] Practitioners (or at [Non-Network] [Non-Participating] Facilities upon prior written authorization by Us); however, [Network] [Participating] Skilled Nursing Center benefits are limited to those which are Medically Necessary and Appropriate and which constitute Skilled Nursing Care:

1. Semi-private room and board accommodations

Except as stated below, We provide coverage for Inpatient care for:

a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.

Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if You, in consultation with the [Participating] Practitioner, determine that a shorter length of stay is medically appropriate.

As an exception to the Medically necessary and Appropriate requirement of this Contract, We also provide coverage for the mother and newly born child for:

a) a minimum of 48 hours of in-patient care in a Participating Hospital following a vaginal delivery; and

b) a minimum of 96 hours of in-patient care in a Participating Hospital following a cesarean section.

We provide such coverage subject to the following:
a) the attending Practitioner must determine that in-patient care is medically necessary; or
b) the mother must request the in-patient care.
[As an alternative to the minimum level of inpatient care described above, the mother may elect to participate in a home care program provided by Us.]

2. Private accommodations will be provided only when Medically Necessary and Appropriate as certified by Your attending Practitioner in concurrence with your Primary Care Physician [or Care Manager] and approved in advance by Us. If You occupy a private room without such certification You shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the [Network] [Participating] Hospital or the [Network] [Participating] Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services. We also cover reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts
20. Private duty nursing only when Medically Necessary and Appropriate as certified by the [Network] [Participating] Specialist Practitioner or other attending Practitioner in concurrence with Your Primary Care Physician [or Care Manager] and approved in advance by Us.
21. The following transplants, when Medically Necessary and Appropriate: Cornea, Kidney, Lung, Liver, Heart, Heart-Lung, Heart Valves, Pancreas.
22. Allogeneic bone marrow transplants.

[23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma Neuroblastoma, and Breast Cancer when approved in advance by Us, if You are participating in a National Cancer Institute sponsored Clinical trial.]

[23. Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
24. Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

d) **BENEFITS FOR SUBSTANCE ABUSE AND NON-BIOLOGICALLY-BASED MENTAL ILLNESSES.** The following Services are covered when rendered by a [Network] [Participating] Practitioner at Practitioner's office [, Health Center] or at a [Network] [Participating] Substance Abuse Center upon prior written referral by Your [Primary Care Physician] [[or] Care Manager]. Please note that this section does **not** address coverage for a Biologically-based Mental Illness.

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits or Partial Hospitalization days during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by Your Primary Care Physician [or Care Manager] for the abuse of or addiction to drugs and Non-Biologically-based Mental Illnesses. Payment for non-medial ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by Your Primary Care Physician [or Care Manager], for up to sixty (60) more Outpatient visits or Partial Hospitalization days by exchanging one or more of the inpatient hospital days described in paragraph 2 below where each exchanged inpatient day provides two outpatient visits.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of Inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the Substance Abuse, referral services for Substance Abuse or addiction, and Non-Biologically-based Mental Illnesses. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, Nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Repeat Detoxification Treatment**. Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

Court-ordered Substance Abuse or Non-Biologically-based Mental Illnesses admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as described above.

e) **BIOLOGICALLY-BASED MENTAL ILLNESS**. We cover treatment of a Biologically-based Mental Illness in the same way as We would cover any other Illness, if treatment is

rendered by a [Participating Provider] [Network Practitioner] upon prior written referral by Your [Primary Care Physician] [[or] Care Manager]. We do not pay for Custodial Care, education or training.

f) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a [Participating Provider] [Network Practitioner] at Practitioner's office [, Health Center] or at a [Network] [Participating] Substance Abuse Center upon prior written referral by Your Primary Care Physician [or Care Manager].

1. **Outpatient.** You are entitled to receive up to twenty (20) Outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by Your [Primary Care Physician] [or Care Manager] for the abuse of or addiction to alcohol. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by Your [Primary Care Physician] [or Care Manager], for up to sixty (60) more Outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the Alcoholism, and referral services for Alcoholism. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. **Repeat Detoxification Treatment**. Repeated detoxification treatment for chronic Alcoholism will not be covered unless in Our Sole Discretion it is Determined that You have been cooperative with an on-going treatment plan developed by a [Network] [Participating] Practitioner. Failure to comply with treatment shall constitute cause for non-coverage of Alcoholism services.

Court-ordered Alcoholism admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

g) **MEDICAL EMERGENCY CARE BENEFITS - WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by Your Primary Care Physician [or Care Manager] in the event of a Medical Emergency as Determined by Us [or the Care Manager].

1. Your Primary Care Physician [or Care Manager] is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to Your health, You shall call Your Primary Care Physician [or Care Manager] [or Health Center] [or Us] prior to seeking Medical Emergency treatment.

2. We will cover the cost of Medical Emergency and medical Hospital services performed within or outside Our service area without a prior written referral only if:

a) Our review determines that Your symptoms were severe and delay of treatment would have been detrimental to Your health, the symptoms occurred suddenly, and You sought immediate medical attention. A near-term delivery is not a Medical Emergency.
b) The service rendered is provided as a benefit under this Contract and is not a service which is normally treated on a non-emergency basis; and
c) We and Your Primary Care Physician [or Care Manager] are notified within 48 hours of the Medical Emergency service and or admission and We are furnished with written proof of the occurrence, nature and extent of the Medical Emergency services within 30 days. You shall be responsible for payment for services received unless We Determine that Your failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event You are hospitalized in a [Non-Participating] [Non-Network] Facility, coverage will only be provided until You are medically able to travel or to be transported to a [Network] [Participating] Facility. If You elect to continue treatment with [Non-network] [Non-Participating] Providers, We shall have no responsibility for payment beyond the date You are determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the reasonable cost as Determined by Us. Reimbursement may be subject to payment by You of all Copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to the [Network] [Participating] Provider.

4. Coverage for Medical Emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after You have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or You shall be responsible for payment.

5. The Copayment for a Medical Emergency room visit will not apply in the event that You were referred for such visit by Your Primary Care Physician [or Care Manager] for services that could have been rendered in the Primary Care Physician's office or if You are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

h) **THERAPY SERVICES.** The following Services are covered when rendered by a [Network] [Participating] Provider upon prior written referral by Your Primary Care Physician.

1. Speech therapy, Physical therapy, Occupational therapy and Cognitive therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a [Network] [Participating] Provider by Your Primary Care Physician [or Care Manager]. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that Your Primary Care Physician [or Care Manager] certifies in writing that the treatment will result in a significant improvement of Your condition within this time period and treatment is approved in writing by Us.

2. Chelation therapy, Chemotherapy treatment, Dialysis treatment, Infusion therapy, Respiration therapy, and Radiation therapy.

i) **HOME HEALTH BENEFITS.** The following services are covered when rendered by a [Network] [Participating] Provider, including but not limited to a [Network] [Participating] Home Health Agency, as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of Your Primary Care Physician [or Care Manager].

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.

2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to You is skilled in nature.

3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of Your medical condition.

4. Therapy Services as set forth above.

5. Hospice Care if You are terminally Ill or terminally Injured with life expectancy of six months or less. Services may include home and Hospital visits by Nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in Our Determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

j) **THERAPEUTIC MANIPULATION**. The following services are covered when rendered by a [Network][Participating] practitioner upon prior Referral by a Member's Primary Care Physician [or the Care Manager]. We limit what We cover for Therapeutic Manipulation to 30 visits per Calendar Year. Services and supplies beyond 30 visits are not covered.

k) **DENTAL CARE AND TREATMENT** - We cover the diagnosis and treatment of oral tumors and cysts; and the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:
1. the Injury occurs while You are covered under any health benefit plan;
2. the Injury was not caused, directly or indirectly by biting or chewing; and
3. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

For a Member who is severely disabled or who is a Child under age 6, We cover:
a) general anesthesia and Hospitalization for dental services; and

b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Contract which requires Hospitalization or general anesthesia.

EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not Medically Necessary and Appropriate.

Any service provided without prior written Referral by the Member's Primary Care Physician [or Care Manager] except as specified in this Contract.

Any therapy not included in Our definition of Therapy Services.

Artificial drugs and surgical procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, except as stated in this Contract; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract. .

Dose Intensive Chemotherapy, except as otherwise stated in this Contract.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Contract.

Extraction of teeth, including bony impacted teeth.

Eye examinations to determine the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Contract; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider unless You were referred to the Provider by Your Primary Care Physician.

Hearing aids and hearing exams to determine the need for hearing aids or the need to adjust them.

Herbal medicine.

Hypnotism.

Illness or Injury which is covered or could have been covered for services provided under workers' compensation, employer's liability, occupational disease or similar law.

Membership costs for health clubs, weight loss clinics and similar programs.

Marriage, career or financial counseling, sex therapy or family therapy.

Methadone maintenance.

Non-prescription drugs or supplies, except:
a) insulin needles and syringes and glucose test strips and lancets
b) colostomy bags, belts and irrigators.

Nutritional counseling and related services, except as otherwise stated in this Contract..

Pre-Existing Condition Limitations:
We do not cover services for Pre-Existing Conditions until You have been covered by this Contract for twelve months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition.
EXCEPTION: The Pre-Existing Conditions Limitation does **not** apply to a Federally Defined Eligible Individual, as defined in this Contract, provided he or she applies for coverage within 63 days of termination of the prior coverage.

In addition, this limitation does **not** affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. The Pre-Existing Condition Limitations do not apply to a Dependent who is a newborn Child, an adopted Child or who is a Child placed in the household for adoption if You enroll the Dependent and agree to make any required payments within 31 days after birth, adoption, or placement for adoption. Additionally, this limitation does not apply to any new benefits mandated by statute or regulation once You have satisfied one Pre-Existing Condition Limitation through elapsed time, waiver and/or credit.

Continuity of Coverage
The Pre-Existing Condition limitation does **not** apply to a Member who was covered under Creditable Coverage provided there has been no more than 31 days lapse in coverage, measured from the last date the Creditable Coverage was in force on a premium paying basis, for a condition covered by that Creditable Coverage, if the Member: has been treated or diagnosed by a Practitioner for a condition under that Creditable Coverage; or satisfied a 12 month Pre-Existing Condition limitation.

Similarly, We will **credit** the time a Member was previously covered under Creditable Coverage for a condition covered by that Creditable Coverage, if the Creditable Coverage was continuous to a date not more than 31 days prior to the effective date of this Contract, measured from the last date the Creditable Coverage was in force on a premium paying basis.

[Prescription Drugs: We do not cover an initial prescription or refill that exceeds the lesser of: the amount prescribed by the Participating Provider and the amount shown below that applies to the Prescription Drug:

a) For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90)day supply.
b) For all other Prescription Drugs:

1) a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or
2) sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;
3) a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointment, enemas, etc.); or
4) one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or
5) one (1) vial containing no more than fifteen (15) milliliters of any optic or ophthalmic product; or
6) two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or
7) three(3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

a) dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or
b) dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

Allergy and biological sera, therapeutic devices or appliances are not covered as Prescription Drugs.]

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine Foot Care, except:
a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal or corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:
a) eligible for payment under either federal or state programs (except Medicaid and Medicare) . This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which You would not have been charged if You did not have health care coverage;
d) for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
e) for which the Provider has not received a certificate of need or such other approvals as are required by law;
f) furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
g) needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
h) provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Injury; or (c) the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
i) provided by or in any locale outside the United States other than in the case of a Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent;
j) provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
k) received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
l) rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Contract;
m) which are specifically limited or excluded elsewhere in this Contract;

n) which are not Medically Necessary and Appropriate, except as otherwise stated in the Contract.;
o) which You are not legally obligated to pay.

Special medical reports not directly related to treatment of the Member (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Transplants, unless otherwise specifically covered, and non-human organ transplants.

Transportation; travel.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

APPEALS PROCEDURE

[Appeals Procedure: Variable by Carrier as approved by the State of New Jersey.]

RIGHT TO RECOVERY - THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits or arranged [or provided] services or supplies and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a) a third party settlement;
b) a satisfied judgment; or
c) other means.

The repayment agreement shall be binding upon the Covered Person whether:

a) the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b) the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Member to the extent such benefits, services or supplies would duplicate whole or partial payments, services or supplies such Member received from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes such repayment.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A Member may be covered under this Contract and covered by or eligible for coverage under Medicare. This provision allows Us to coordinate the services and supplies We provide with what Medicare pays or what Medicare would pay. We do this so the Member does not receive more in benefits, services and supplies than he or she incurs in charges.

Definitions

“Medicare” means Part A or Part B of Title XVIII of the federal Social Security Act.

"Member" means the person who receives a policy or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a Member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a Member or Dependent under either this Policy or Medicare. For a Member or a Dependent who is eligible for Medicare, items of expense that would have been covered by Medicare, whether or not the Member or Dependent enrolls in Medicare will be considered a paid Allowable Expense. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by Medicare as an allowable expense, whether or not a claim is filed under Medicare.

The amount of reduction in benefits resulting from a Member's or Dependent's failure to comply with provisions of Medicare is not considered an allowable expense to the extent such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Policy if this Policy had been primary. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Member or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Member or Dependent is covered by this Contract and is either covered by Medicare or is eligible to be covered by Medicare, and incurs one or more allowable expense under such plans.

How This Provision Works

We apply this provision when a Member or Dependent is covered by this Contract and is either covered by Medicare or is eligible to be covered by Medicare. We will consider each plan separately when coordinating payments.

Medicare is the primary plan. This Contract is the secondary plan. The primary plan (Medicare) pays first, without regard to this Contract. The secondary plan (this Contract) then pays up to the

remaining unpaid allowable expenses, but neither plan pays more than it would have paid without this provision.

If, when We apply this provision, We cover less than We would otherwise cover, We apply only that reduced coverage against payment limits of this Contract.

Our Right To Certain Information
In order to coordinate benefits, We need certain information. A Member or Dependent must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to request this information from any source.

When coverage that should have been provided by this Contract has been provided by Medicare, We have the right to repay Medicare. If We do so, We are no longer liable for that coverage. And if We provide more than We should have, We have the right to recover the excess coverage.

Small Claims Waiver
We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, We will count the entire amount of the claim when We coordinate.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Contract, You have two options under the terms of Your motor vehicle insurance Contract. The option You select will also determine coverage of any resident relative in the named insured's household who is not a separate named insured under another motor vehicle policy.

a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Contract (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance policy or under similar provisions of a motor vehicle Contract required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Banking and Insurance.

b) You may choose to have primary coverage for such services provided by this Contract.

If You choose this option, We will provide benefits for any Covered Services and Supplies incurred for the diagnosis or treatment of an Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Contract.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Banking and Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Contract, this Contract will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

MEMBER PROVISIONS

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us, or as may otherwise by provided by law, may not be disclosed without the Member's written consent.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Contractholder, coverage may be terminated for the Contractholder as well as any of the Contractholder's Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Appeal Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our [Network] [Participating] Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No [Network] [Participating] Provider or other provider, institution, Facility or agency is Our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any [Network] [Participating] Provider or other provider, institution, Facility or agency.
2. Neither the Contractholder nor any Member is our agent, representative or employee, or an agent or representative of any [Network] [Participating] Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. [Network] [Participating] Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contractholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from [Network] [Participating] Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may Determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate [Network] [Participating] Facility to render services if hospitalization is necessary. Decisions as to Medical Necessity and Appropriateness are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Practitioner referred in writing by the Primary Care Physician [or Care Manager] without notifying the Member that such benefit would not be covered under this Contract.

REFERRAL FORMS

You can be referred for Specialist Services by Your Primary Care Physician [or Care Manager].

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician [or Care Manager].

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Appeal Procedure and We will continue to provide all benefits covered by the Contract during the pendency of the Appeal Procedure. We reserve the right to expedite the Appeal Procedure. If the Appeal Procedure results in a decision upholding position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Appeal Procedure, to terminate this Contract in accordance with Section IX. In such event, We will continue to provide all benefits covered by this Contract for 30 days or until the date of termination, whichever comes first, and We and the Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Contract. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

REPORTS AND RECORDS

HMO is entitled to receive from any provider of services to a Member such information HMO deems is necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Contractholder, for the Contractholder, and for all Dependents covered hereunder, authorizes each and every Practitioner who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]
When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician [and/or a Health Center].

You select a Primary Care Physician from Our Practitioners Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN
Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If You do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will cover services only if We Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER.
The Care Manager will manage authorize Your treatment for a [Mental or Nervous Condition, Substance Abuse, or Alcoholism.] You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

GENERAL PROVISIONS

AMENDMENT
The Contract may be amended, at any time, without Your consent or that of anyone else with a beneficial interest in it. The Contractholder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contractholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:
a) it is shown in an endorsement on it signed by an officer of [Carrier].
b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called

"Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

c) if a change is required by [Carrier], it is accepted by the Contractholder, as evidenced by payment of a Premium on or after the effective date of such change.
d) if a written request for a change is made by the Contractholder, it is shown in an amendment to it signed by the Contractholder and by an officer of [Carrier].

ASSIGNMENT
No assignment or transfer by You of any of Your interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR - MISSTATEMENTS
No clerical error by Us in keeping any records pertaining to Coverage under this Contract will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made. Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Contract.

CONFORMITY WITH LAW
If the provisions of the Contract do not conform to the requirements of any state or federal law that applies to the Contract, the Contract is automatically changed to conform with the requirements of that law.

CONTINUATION OF COVERAGE
If You die while this Contract is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Contract for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Contract provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONTINUING RIGHTS
Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONVERSION PRIVILEGE
If Your Spouse loses coverage due to a divorce, the Spouse may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following

the date the Spouse's coverage under this Contract ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Contract will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT
There will be no contest of the validity of the Contract, except for not paying Premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your coverage or in denying a claim for benefits after such coverage has been in force for two years during Your lifetime.

LIMITATION OF ACTIONS
No action at law or in equity shall be brought to recover on the Contract until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION
Any notices, documents, or other information under the Contract may be sent by United States mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS
We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in Your application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to You for attachment to this Contract.

CONTRACT INTERPRETATION
We shall administer this Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

STATEMENTS
No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE
If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Contract. . Coverage ends at 12:01 a.m. on the date the first of these events occurs.

Also, Dependent coverage ends when the Contractholder's coverage ends.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE
<u>During or at End of Grace Period - Failure to Pay Premiums</u>: If any Premium is not paid by the end of its grace period, the Contract will end [when that period ends.][as of the end of the period for which premium has been paid.]
<u>Termination by Request</u> - If You want to replace this Contract with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which Premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:

a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]

b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)
c) termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)
d) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
e) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)
f) subject to the statutory notification requirements, We cease to do business in the individual health benefits market;
g) subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may have become eligible for coverage.
h) [You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]

THE CONTRACT

The entire Contract consists of:
a) the forms shown in the Table of Contents as of the Effective Date;
b) the Contractholder's application, a copy of which is attached to the Contract;
c) any riders, endorsements or amendments to the Contract; and
d) the individual applications, if any, of all Members.